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No. 87-994

Supreme Court, U.S.
FILED
FEB 11 1988
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

VS.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBURG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. The California Insurance Tax is a tax upon the privilege of doing insurance business in California. The tax is measured by the gross premiums cost to the insured parties of their insurance coverage. To compute the tax, that measure must be valued in dollars. In this case, California is taxing the insurance business of Metropolitan Life Insurance Company as to certain group insurance policies under which the insureds, petitioners' employees, are paying their premiums in the form of labor. In order to assign a dollar value to those labor premiums, California has made a purely computational reference to the equivalent dollar amounts of certain policy claims; these claims (1) were fully funded by the labor premiums, (2) were paid to the insureds, pursuant to the terms of a Metropolitan policy rider, from dollars retained in the employers' accounts, and (3) were claims which insurer Metropolitan was obligated to pay if they were not paid from the employers' accounts for any reason. Did the Court of Appeals properly hold that California's method of imposing insurance tax liability upon Metropolitan is protected by the ERISA saving clause and not affected by the ERISA deemer clause?

2. If this Court were to grant the petitioners' petition, respondent would urge several additional grounds to support the judgment reached by the Court of Appeals; these grounds would raise the following issues:

   a. Does the California Insurance Tax, which does not directly or indirectly regulate the contents or procedures of any ERISA plan, "relate to" an ERISA "plan" in such a way as to merit application of ERISA's § 514(a) preemption clause?

   b. When non-taxpayers such as petitioners enter into a contract to reimburse the taxpayer insurance company for costs incurred from such taxation, does such a voluntary agreement give petitioners standing to sue to enjoin collection of the tax, unaffected by the Tax Injunction Act?

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STATUTORY AND CONSTITUTIONAL PROVISIONS

Petitioners have set forth selected portions of section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144, omitting applicable portions such as subsection (d) and including subsection (b)(5)(B)(i), which is only applicable to the Hawaii Prepaid Health Care Act under the terms (omitted by petitioners) of subsection (B)(5)(A). Section 514 of ERISA is set forth in its entirety in Appendix A hereto, along with the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015), the Tax Injunction Act (28 U.S.C. § 1341), and the primary California constitutional and statutory provisions regarding the Califor-

nia Insurance Tax (Cal. Const., art. XIII, § 28; Cal. Rev. & Tax. Code §§ 12201, 12221).

STATEMENT OF THE CASE

Respondents dispute many of the argumentative statements in petitioners' Statement of the Case. Respondents believe that denial of the petition will follow as a natural result of clarification of the record. Respondents' statement of the case will be a succinct presentation of the case before this Court; the more lengthy discussion of how petitioners have misstated the case is contained in the argument, below at pages 5-13.

Petitioners' employees were the insured parties under insurance policies issued by the Metropolitan Life Insurance Company ("Metropolitan"). Appellants' Excerpt of Record (hereinafter "A. Exc.") 1203-1240 (Appendix B hereto). Added to the basic insurance policies were so-called "Mini-Met" riders, which reduced none of the insurance benefits provided to the employees under the policies. A. Exc. 590-640. Said riders did change several procedural aspects with regard to the amounts needed to pay claims up to the "trigger point", which is the aggregate amount of claims that actuarially are predicted to arise under said policies for each set period. Instead of directly turning over these amounts to Metropolitan as the net premium portion of the insurance premiums, the employers retain those amounts in their own accounts but make the funds available for withdrawal for payment of claims up to that "trigger point". A. Exc. 569, lines 6-9, 572, 591-92 (Appendix C hereto at C2-C4). Once the trigger point has been reached, Metropolitan pays all remaining claims made for that period. A. Exc. 591 (App. C2-C3). Metropolitan also retains insurance liability under its policies to pay out of its own funds any valid pre-trigger point claims that are not paid from the employers' funds for any reason (such as an employer's insolvency). A. Exc. 591 (App. C3). With the exception of one policy, Metropolitan also retains control of approval as to *all* claims and writes the checks for pre-trigger point claims out of the employers' accounts. A. Exc. 571-72, 579-80.

One of Metropolitan's major purposes in drafting the "Mini-Met" rider was to try to avoid approximately 90 percent of state insurance taxes paid under the standard contract. A. Exc. 1182, lines 16-19, 1247. When California accepted the "Mini-Met" form for use in California, Metropolitan was informed that it would not gain such tax benefits under California law. A. Exc. 1246.

In a case involving pre-ERISA years and other employers but the same Metropolitan policy and rider forms, the California Supreme Court held as follows: (1) under the policy with the "Mini-Met" rider added, Metropolitan continued to be the only insurer; (2) the California Insurance Tax is measured by gross premiums, the total cost of the insurance to the insured parties, who (under Metropolitan's policy documents) were the employees; (3) insurance premiums consist of two elements, the net premium (to fully fund the expected level of aggregate claims) and the loading (to fund the administrative costs of the insurer and to pay for the insurer's assumption of the insurance risk that claims outlays will exceed the expected levels); (4) through the provision of labor the insured employees bore the full expense of all insurance coverage provided under the policy; (5) the employers received the value of that labor as agents of Metropolitan; (6) since the dollar amounts paid out as pre-trigger point claims from the employers' accounts were fully funded by the net premiums element of the employees' labor premiums, the same dollar amounts could be assigned to value net premiums, then added to the dollar amounts paid directly to Metropolitan (equivalent to the loading premiums element) in order to give a dollar figure to the gross premiums measure of the tax. *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal.3d 649, 658, 659-662; 652 P.2d 426, 186 Cal. Rptr. 578 (1982) (Pet. 37a, 49a-55a).

Metropolitan is not a party to the current action; however, Metropolitan has several tax refund actions pending in the California state courts to test the California approach for ERISA years. A. Exc. 83-271, 340-512. Petitioners in the current case are employers whose employees are insured under Metropolitan policies with the "Mini-Met" rider, and petitioners claim that

said policies cover the benefits of ERISA plans. Petitioners, claiming that California's actions constitute an indirect tax on ERISA plans, seek a declaration that ERISA pre-empts California's method of calculating its insurance tax, as well as an injunction from continuing collections to the extent they are based on such calculations. A. Exc. 11-13.

The District Court gave petitioners such declaratory and injunctive relief. Pet. 33a-34a. In an opinion written by Circuit Judge Anthony M. Kennedy, the Court of Appeals reversed, holding that the California tax at issue is preserved by the ERISA saving clause and not affected by the ERISA deemer clause. The Court of Appeals decision recognizes that California is not taxing ERISA benefits; it is using the claims paid from the employers' funds only as a means of valuing the total cost of the insurance provided, the gross premiums. *General Motors v. California State Bd. of Equalization*, 815 F.2d 1305, 1310-1311 (9th Cir. 1987) (Pet. 12a-15a). Rehearing was denied, and request for rehearing en banc was rejected. Pet. 35a-36a.

There is no conflicting decision from any other Court of Appeals panel in any Circuit.

ARGUMENT

I

PETITIONERS ATTEMPT TO RAISE ISSUES WHICH DO NOT REFLECT THE SUBSTANCE OF THE RECORD OR THE ACTUAL APPLICATION OF THE CALIFORNIA TAX; WHEN THE CASE IS CLARIFIED, THE ERISA SAVING CLAUSE AND DEEMER CLAUSE ISSUES ARE EASILY RESOLVED IN FAVOR OF THE CALIFORNIA TAX

A. Introduction

The arguments made in GM's[1] petition are not consistent with the record in this case. Contrary to GM's glib presentation in its petition, the record of this case establishes the following:

1. Every benefit involved in this case was covered by an insurance policy issued by the Metropolitan Life Insurance Company (hereinafter "Metropolitan"), under which the employees were the insureds;

2. Metropolitan had insurance obligations to the insured employees as to each and every said benefit;

3. Neither the employers nor the ERISA plans bore any insurance risk and thus were not "self-insured";

4. The California Insurance Tax was imposed on Metropolitan's privilege of doing insurance business in California, and the tax was measured by the premiums cost to the insured employees, not the cost to the plan;

5. Both the California Supreme Court and the Ninth Circuit Court of Appeals have recognized that, under the types of insurance policies involved here, California's application of the tax to Metropolitan does not in any way impose a tax on benefits paid from employers' funds: the dollar amounts of those benefits are used for purely computational purposes because they are necessarily reflective, dollar for

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[1] For purposes of brevity, references to "GM" in this brief include reference to both petitioners, General Motors Corporation and American National Red Cross.

dollar, of net premium values which have been paid in the form of labor by the insured employees.

GM concedes (Pet. 17) that there is no challenge to the power of California to tax an insurance company even though the insurer then passes the costs of said insurance tax on to the employers or the ERISA plans. Under GM's approach California can tax Metropolitan for the insurance business it conducts, and California can measure its tax by the premiums costs to the insured employees of obtaining Metropolitan's insurance coverage; the record in this case shows that California has done just that. However, GM argues that ERISA preempts the California tax to the extent that in doing so California makes any arithmetical reference to pre-trigger point benefits received by the employees, even if said reference is the most accurate way to determine part of the value of the employees' premiums costs. It makes no sense to conclude that a valid tax with a valid measure is rendered invalid because its measure is calculated in the most accurate available manner. Federal law does not support that nonsensical conclusion. California has only taxed Metropolitan for insurance business it conducts in California, and California has properly and accurately measured that tax by the premiums costs to the insured employees; under these circumstances there is no ERISA preemption, and GM's petition for writ of certiorari should be denied.

B. The Record Demonstrates That Metropolitan Provided Insurance Coverage to the Employees for All the Benefits Involved in This Case

GM's petition repeatedly asserts that Judge Kennedy's Ninth Circuit opinion permits California unlimited taxing powers as long as an insurance company provides the slightest amount of insurance coverage with respect to employees involved in an ERISA plan. Pet. 8, 10 n. 5, 13, 14. Such assertions are not based on references to the actual insurance documents contained in the record; they are based on assumptions that are directly contrary to the record. Petitioners, maintaining that "the insurance contracts are not relevant to these proceedings" (A. Exc. 1370) did not present to the lower court the specific Metropolitan group policies for petitioners' employees. However, the record does contain the

Metropolitan basic group insurance policy form which was originally presented by stipulation in the California case of *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal.3d 649 (1982) (Pet. 37a), and petitioners have accepted the facts as found in the California Supreme Court decision. (Transcript of hearing of August 24, 1984, page 5, lines 18-19.) This Metropolitan group policy form with excerpts from its standard policy riders (A. Exc. 1203-1240) is Appendix B ("App. B") to this brief; a representative sample of the so-called "minimum premium" or "Mini-Met" amendments or riders to existing group policies for petitioners' employees (A. Exc. 590-596), is Appendix C ("App. C") hereto. Considered together, these documents illustrate the scope of Metropolitan's business of insurance; the true illustration is strikingly dissimilar to the picture painted in GM's petition.

It is clear from the terms of the Metropolitan group policy form that (1) the employees are the insured parties under the policy and (2) under this policy Metropolitan is providing insurance as to all listed benefits (A. Exc. 1203-1209, 1215-1240; App. B1-B7, B15-B25). The "Mini-Met" rider, which amends the basic policy only in certain respects, does not change the status of the employees as the insureds; nor does it reduce in the slightest the level of benefits to which the insured employees are entitled under the Metropolitan insurance policy. Under the rider's terms, Metropolitan retains potential liability to the insured employees for the payment of *all* valid claims, whether or not aggregate claims have exceeded the trigger point; although the employer has agreed with Metropolitan to pay all claims up to the trigger point, the rider continues Metropolitan's obligation to pay such claims if the employer does not, even if the employer should become insolvent. See, *e.g.*, A. Exc. 591 (para. 4) (App. C2-C3); *Metropolitan Life Insurance Company v. State Board of Equalization*, 32 Cal.3d at 657 n. 3 (Pet. 49a).

As between the employer and Metropolitan, under the "Mini-Met" rider GM has agreed to fund all "expected (*i.e.* pretrigger point) benefits," with Metropolitan paying all claims once that aggregate predicted level has been reached. Pet. 7; A. Exc. 569, lines 7-9. Since it is the insured employees that are actually paying the premiums for their insurance coverage through their

labor (*Epmeier v. United States* 199 F.2d 508, 510 (7th Cir. 1952); *Metropolitan Life Insurance Company v. State Board of Equalization, supra*, at 661 (Pet. 54a-55a)), and since the net premiums element of such insurance premiums always includes payment sufficient to fund expected claims (see A. Exc. 570, lines 14-17, 578-79; and the opinion below, 815 F.2d at 1310 (Pet. 13a) and authority cited therein), GM has assumed absolutely no insurance risk under the Mini-Met rider. As before, it is Metropolitan which continues to bear the entire insurance risk (in GM's own affiant's terms, the "genuine insurance component," A. Exc. 571, line 8) that the aggregate level of claims will exceed predictions. In other words, Metropolitan continued as the only true insurer for all the benefits provided under this policy; GM was not "self-insured" in that it was neither the insured party in the first place under the policy nor did GM bear any insurance risk of having to pay out more than it had received in value from its employees to fund the entire insurance coverage. Thus GM itself, in a booklet describing ERISA rights, assured its employees that "[T]he GM Insurance Program is an insured welfare benefit plan . . . ," and that "*all* life and disability benefits, as well as Health Care benefits for certain employees, are provided through the Metropolitan Life Insurance Company." A. Exc. 1770 (emphasis added).[2]

In addition to (and apparently because of) the potential payment obligations which Metropolitan retained as to all claims under the insurance policy, Metropolitan continued to be intimately involved in the administration of all claims. Metropolitan had the final say as to allowance or disallowance of *all* claims litigation and settlements. See, *e.g.*, A. Exc. 592, para. 8 (App. C4-C5). Except for one area of one of the GM policies, Metropolitan apparently performs the administrative claims duties for

[2] Similarly, the booklet describing the "Group Insurance Plan" for the American Red Cross staff (A. Exc. 1853-1883) set forth the available benefits and simply stated: "The plan is underwritten by the Metropolitan Life Insurance Company." A. Exc. 1854. The insurance provided by Metropolitan in this case bears no resemblance to the arrangement as described in *General Electric Co. v. Gilbert*, 429 U.S. 125, 128 n. 3 (1976), upon which GM relies (Pet. 7).

all claims and writes the checks for pre-trigger point benefit claims out of the employers' accounts. A. Exc. 571-72, 579-80.

It is this factual context, not the fanciful version drawn by GM in its petition, to which California applies its insurance privilege tax. It is ironic that GM, whose petition repeatedly decries any possible elevation of form over substance (Pet. 1-2, 15), expects this Court to base its actions in this case on mere labels which GM has applied to surface appearances resulting from Metropolitan's artful drafting of its Mini-Met rider, without any consideration of the actual insurance relationships which form the substance of Metropolitan's continuing insurance coverage.[3] The terms of the Ninth Circuit's decision properly are limited to the facts in the record before it. GM has no basis for its assertions that the Ninth Circuit's *GM* holding supports unlimited state taxation without regard to the amount of insurance actually provided by the insurance company: the Ninth Circuit holds that the challenged procedures are used only as a means of capturing the total cost of the "insurance provided" (Pet. 13a); this holding is supported by reference to the California Supreme Court's *Metropolitan* decision, which properly held that Metropolitan was the "one insurer under the Mini-Met package" (32 Cal.3d at 659 (Pet 51a)) and which held that under California law the insurer's tax amount was to be based on the total cost of "the insurance coverage provided" to the insured employees (32 Cal.3d at 660 (Pet. 53a)).[4] This case must be decided on the basis of the record

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[3] One of Metropolitan's primary goals in drafting the Mini-Met rider was to reduce insurance tax liability (App. Exc. 1182, lines 16-19, 1247); at the time the Mini-Met rider form was accepted for use in California, Metropolitan was informed that it would not achieve those tax benefits under California law (App. Exc. 1246).

[4] Instead of supporting GM's position (see Pet. 10 n. 5), the Ninth Circuit's reference to *Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922 (9th Cir. 1986) and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) only serves to indicate the Ninth Circuit's awareness of the scope of the insurance coverage provided by Metropolitan in this case. In his *GM* opinion Judge Kennedy distinguishes *Moore* and *Pacyga* on the basis that "insurance [was] not involved in any meaningful sense in either case" (Pet. 14a-

and opinion actually before this Court, not on GM's purported fears of how California or other states might attempt to apply the *GM* result to other, broader circumstances.

C. Petitioners' Arguments Are Based on a Faulty Premise, for California Is Neither Taxing ERISA Plan Benefits Nor Treating Them as Premiums

Throughout the petition GM bases its arguments on repeated statements that California has imposed a tax on ERISA plan benefits. See, *e.g.*, Pet. 2, 12, 14, 15. Indeed, in its first paragraph the petition asks this Court to determine whether ERISA permits "purposeful . . . state taxation of ERISA benefits . . ." Pet. 2. In this regard GM asserts that the California Supreme Court has deemed plan benefits to be insurance premiums (see Pet. 7, 16-17, 18), and that the Ninth Circuit did not disagree with the District Court's conclusion that California was indirectly taxing ERISA benefits (Pet. 10, 15 n. 9). All such statements in the petition are simply wrong; they are based on misinterpretations of the opinions of both the California Supreme Court and the Ninth Circuit Court of Appeals.

Metropolitan's drafting of its "Mini-Met" rider has resulted in California's reference to dollar amounts of benefits paid from employers' funds, but those amounts are used purely as a computational tool in valuing the *premiums that are provided by the employees*, not the employers. A review of California's Insurance Tax and its true application in this case discloses that California is not treating such benefits as premiums and is not taxing such benefits directly or indirectly.

The California Constitution imposes a privilege tax "on each insurer doing business" in California, measured by the amount of "gross premiums" which the insurer receives each year. Cal. Const., art. XIII, § 28; Cal. Rev. & Tax. Code, § 12201, 12221; *Carpenter v. Peoples Mutual Life Insurance Co.* 10 Cal.2d 299, 302, 74 P.2d 508, 510 (1937). Dealing with pre-ERISA years, in *Metropolitan Life Insurance Co. v. State Board of Equalization, supra*, 32 Cal.3d 649 (Pet. 37a), the California Supreme Court

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15a), thus recognizing that a much greater amount of insurance was provided by Metropolitan in *GM*.

ruled on the issue of how to calculate the "gross premiums" measure when faced with the surface complexities of Metropolitan's "Mini-Met" arrangement. Drawing upon long-established California insurance tax law, the California Supreme Court held that the entire cost to the insured employees of the insurance coverage provided under the Metropolitan insurance contract was includible in Metropolitan's gross premiums for the years 1967-1969, even though Metropolitan had tried to shield a significant portion of the premiums from the measure of tax.

The California Supreme Court held that the employers were not independent insurers but rather merely received the premiums from the employees as collection agents of Metropolitan. *Id.* at 652, 659 (Pet. 42a, 51a). *The Court further held that the insured employees, through their provision of labor, bore the full expense of the insurance coverage*: The Court recognized that for every dollar of pre-trigger point claims (i.e. benefits) paid under the terms of the Metropolitan policy from the employers' funds, the insured employees had paid in a dollar's worth of net premiums in labor; thus under "Mini-Met" the employers' funds could not be responsible for paying out (in pre-trigger point claims and in direct payments to Metropolitan) any more than the employers had received in labor premiums from their employees, leaving Metropolitan to bear the substantial insurance risk. *Id.* at 658-59, 660-62 (Pet. 49a-51a, 53a-55a). The California Supreme Court held that the entire cost of the insurance to the insured employees (including an amount equal to the payments made from the employers to Metropolitan and an amount equivalent to the payments made out of the employers' funds to satisfy employee claims up to the trigger point) was included in the gross premiums measure of Metropolitan's tax under California Constitution Article XIII, section 14 4/5 (now sec. 28) and California Revenue and Taxation Code sections 12201 and 12221. *Id.* at 659-62 (Pet. 51a-55a).

Given the above, it is wholly incorrect and improper for GM continually to assert that California is imposing a tax on plan benefits. Rather, California imposes its tax upon Metropolitan for its exercise of the privilege of doing insurance business in California; California measures this tax by the gross premiums received

by the insurer, the amount of which is set under California law by determining the cost to the insureds of obtaining the insurance.[5] In the current context California's determination of such total costs to the insureds has been made more complex by Metropolitan's generation of the "Mini-Met" smokescreen, which (as shown above) did not alter Metropolitan's basic insurance relationship with the insured employees. Because of the drafting complexities injected by Metropolitan, California uses, *only as part of its computation* of the insured employees' premiums costs, the dollar amounts of the claims benefits paid from employer funds. A full review of the California Supreme Court's decision makes it clear that those dollar amounts are used arithmetically because they are necessarily reflective, dollar for dollar, of premium values incurred as insurance costs by the insured employees.

Contrary to GM's assertions, in the present case Judge Kennedy's opinion for the Ninth Circuit clearly recognizes that the claims payments paid from GM's funds are not being treated as premiums and are not being taxed by California. The Ninth Circuit, recognizing that the California Insurance Tax "is calculated in terms of premiums," further notes that under the "Mini-Met" facts California uses the dollar amounts of pre-trigger point claims payments solely as a computational reference:

> "Concededly, the tax is calculated with reference to benefit payments. The payments, however, are used only as a means of capturing the total cost of the insurance provided, the amount which appellants' premiums tax seeks to reach. *Metropolitan Life Ins. Co. v. State Bd. of Equalization,* 32 Cal.3d 649, 660, 652 P.2d 426, 186 Cal.Rptr. 578 (1982). Total cost has two elements, the net premium and the loading. The net premium is the amount which, invested properly, will yield a fund sufficient to pay expected claims. The loading is the amount added to the net premium to

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[5] GM tries to confuse the matter by referring to costs to "the plan" or costs to the employers; there can be no valid question that California has measured its Insurance Tax by the insurance premiums costs to the insured *employees. Id.* at 659-62 (Pet. 52a-55a).

cover the insurer's administrative costs and compensate it for assuming the risk that claims will exceed expected levels. *Allstate Ins. Co. v. State Bd. of Equalization*, 169 Cal.App.2d 165, 168, 336 P.2d 961, 964 (1959). Under a traditional policy, both elements are included in the premium paid the insurer, making that premium an accurate measure of the total cost of the insurance provided.

> "Here, the premium paid the insurer includes only the loading element, so a method for determining the dollar amount of the net premium element is necessary. As the benefits paid by the plans equal the net premium under a traditional policy, appellants have referred to those payments in calculating the tax. This reference, which is used to measure the cost of insurance provided accurately, does not deprive the tax of the protection of the saving clause, for the incidence of the tax remains on the insurer, not the plans." 815 F.2d at 1310 (Pet. 13a-14a).

Even if the measure of California's tax were considered to be the pre-trigger point claims, that would not convert this tax on the privilege of doing California Insurance business into a tax on those claims benefits. *See Educational Films Corp. v. Ward*, 282 U.S. 375, 389-390 (1931); *Flint v. Stone Tracy Co.*, 220 U.S. 107 (1911). Petitioners attempt to avoid this established rule by citing *American Bank & Trust Co. v. Dallas County*, 463 U.S. 855, 862 (1983), and *Ramah Navajo School Board v. Bureau of Revenue*, 458 U.S. 832, 845 (1982). Petitioners fail to mention that both these cases come within specific exceptions to the *Flint v. Stone Tracy* rule: *American Bank & Trust Co.* involved a federal statute that had been amended specifically to prohibit inclusion of certain types of exempt income in *any* computation involving a state tax, and *Ramah*, involving pre-emption of state taxation with regard to Indian tribes, explicitly noted that that type of pre-emption question "is not controlled by standards of pre-emption developed in other areas." 458 U.S. at 838. Neither exception applies here.

D. California's Application of Its Insurance Tax Is Protected by the ERISA Saving Clause and Not Pre-empted by the Deemer Clause

Once one dispels the smokescreen generated by petitioners, so that the scope of insurance provided by Metropolitan and the actual application of the California Insurance Tax become clear, there can be no real question that the Ninth Circuit has correctly held that California's tax, as applied in this case, is preserved by the ERISA saving clause. In the conclusion to their petition, petitioners concede "the power of the states to tax insurance companies even though the costs of the tax are passed through by the insurer to an ERISA plan." Pet. 17. Thus petitioners only challenge "the power of the states to tax benefits paid out by ERISA plans under the theory that such benefits constitute insurance premiums." Pet. 17-18. Since, as shown above, California does not here treat such benefits as premiums and does not here tax such benefits, petitioners are challenging phantoms that have no existence in the record now before this Court.[6]

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[6] Five of the six respondents herein apparently were named because of their membership on the State Board of Equalization, which assesses the California Insurance Tax (Cal. Const. art. XIII, § 28(h)). After its staff makes the preliminary assessment, the Board itself makes the final administrative review of whether an assessment will stand. If the Board denies refund relief, its decision is subject to full review by the California courts. The 1983 bulletin attributed by petitioners to "respondents" (Pet. 8) was issued solely by respondent Bunner, who has never been a member of the Board of Equalization and who is no longer Insurance Commissioner. No respondent would subject "Mini-Met" claims payments to taxation, and all respondents agree that such claims amounts are used only for the computational reference discussed above to measure Metropolitan's insurance business. A. Exc. 947. In any event, the issues in this case are limited by the record of this case; speculation as to what California or other states might do in other circumstances (see Pet. 8) is not a case or controversy which is now properly before this Court. Such speculative issues must first be considered and decided on properly developed trial records in the appropriate courts.

Even though the ERISA issue as framed by the petitioners is inapplicable to the record of this case, the petition's discussion of ERISA principles calls for clarification.

The Ninth Circuit has correctly indicated that, under this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739-740 (1985), the ERISA insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), "must be construed broadly, with due regard for the states' traditional powers in the field of insurance." 815 F.2d at 1310 (Pet. 12a). The Ninth Circuit also correctly holds that state taxation of the business of insurance was preserved under the saving clause:

> "The saving clause must also be construed to cover taxation of insurance. The clause preserves the McCarran-Ferguson Act's reservation of the business of insurance to the states. *Metropolitan*, 105 S.Ct. at 2392 n. 21. *McCarran-Ferguson*, in turn, preserves the states' ability to 'tax and regulate' insurance. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218, 99 S.Ct. 1067, 1076, 59 L.Ed.2d 261 (1979). Thus taxation of insurance, no less than regulation, may fall within the saving clause." 815 F.2d at 1310 (Pet. 12a-13a).[7]

As established above, California has applied its Insurance Tax to Metropolitan's privilege of doing insurance business in California; such a tax comes under the full protection of the McCarran-Ferguson Act. See *Western and Southern L.I. Co. v. Bd. of*

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[7]Subsection (d) of the ERISA section that deals with preemption provides that "[n]othing in this subchapter shall be construed to alter, amend, . . . impair or supersede any law of the United States . . ," thus confirming the full preservation of the McCarran-Ferguson reservation of the insurance business of insurance companies to the states. 29 U.S.C. § 1144(d); see *Northern Group Services v. Auto Owners Ins. Co.*, 833 F.2d 85, 91-92 (6th Cir. 1987).

Also, state taxation has been treated as being included as one type of state "regulation" in other federal pre-emption contexts. See *Wardair Canada, Inc. v. Florida Dept. of Revenue*, ___ U.S. ___, 106 S.Ct. 2369, 2372 (1986); *Ramah Navajo School Board v. Bureau of Revenue*, 458 U.S. 832, 838 (1982).

Equalization, 451 U.S. 648, 652-55 (1981). Unlike the state regulation involved in *Pilot Life Ins. Co. v. Dedeaux*, ___ U.S. ___, 107 S.Ct. 1549 (1987), this California tax is applied only to the insurance business of an insurance company and does not conflict with any of the other substantive or procedural provisions of ERISA.

Three McCarran-Ferguson "business of insurance" factors have been applied to test saving clause protection for non-tax state regulation in this Court's 1985 *Metropolitan* decision (471 U.S. at 742-743) and this Court's 1987 *Pilot Life* decision (107 S.Ct. at 1553-1554). These same factors also can be applied in this tax case to determine that California's tax is indeed being applied to the "business of insurance": (1) California's tax is being applied to Metropolitan's privilege of engaging in arrangements which transfer the risk of loss from the insured employees to Metropolitan (but not to the employers—see above at 7-8); (2) the privilege being taxed is what enables Metropolitan to enter into the policy relationship between Metropolitan as the insurer and the employees as the insureds; and (3) the tax only applies to entities within the insurance industry.

As to the ERISA deemer clause, 29 U.S.C. § 1144(b)(2)(B), the Ninth Circuit has correctly relied upon this Court's 1985 *Metropolitan* decision to conclude that "[t]he tax in issue does not run afoul of the deemer clause." 815 F.2d at 1310-1311; Pet. 14a. This Court's 1975 *Metropolitan* opinion designates "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." 471 U.S. at 747. Here the substance of the record indicates that Metropolitan provided insurance coverage to the insured employees for every benefit at issue, and that both petitioners presented their plans to their employees as insured plans. See above at pp. 7-8.[8] The fact that California, in determining the value of labor premiums

[8] Under the California Supreme Court's application of the "Mini-Met" arrangement, the *employers* are agents of Metropolitan for premium collection and limited disbursement purposes; but the employers are not insurers, for they incur no insurance risk. See above at pp. 7-8. The ERISA *plans* themselves are not even deemed to be agents, and

provided by the insured employees, merely referred to the doliar amounts of claims paid from employers' funds, will not result in "the evisceration of section 514 [29 U.S.C. § 1144]." See Pet. 16-17. That passive use of claims figures is a far cry from the effect of State regulation on the plan in *Metropolitan Life Ins. Co. v. Massachussetts*, wherein the state required insurance companies to carry a type of coverage for continuing benefits which were not otherwise included in the related ERISA plan.

Given the record of this case, including the breadth of the insurance actually provided by California and the very limited computational use California makes of the dollar amounts of the claims payments from the employers' funds, a "common-sense" application of the saving clause and the deemer clause results in no ERISA preemption of California's Insurance Tax as applied here. Under this Court's ERISA decisions, a state law which is protected by the McCarran-Ferguson Act (which protection is in part conditioned on no explicit conflict with the contents of another federal law such as ERISA) and which is imposed specifically and directly upon an insurance company will be protected by the saving clause and will not be pre-empted by the deemer clause. *See Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 739-747; *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1551-1555, 1558.

It would be the ultimate victory of form over substance and the total defeat of common sense to hold that California's computational reference to the dollar amounts of claims, which reference was the most accurate available means of valuing part of the labor premiums paid by the employees for the insurance coverage, must result in the pre-emption of most of California's insurance privilege tax on Metropolitan. Given the scope of Metropolitan's

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neither the plans not the employers are deemed to be engaged in the business of insurance.

It is not necessary here for California to rely upon the holding in *Northern Group Services v. Auto Owners Ins. Co.*, 833 F.2d 85, 95 (6th Cir. 1987), that the deemer clause does not preclude direct state regulation of even self-insuring ERISA plans when there is no demonstrated, specific ERISA uniformity interest which overrides the McCarran-Ferguson interest in state regulation of insurance.

insurance coverage, such a holding would only force California to use a less accurate means of trying to determine the same amount of the fully appropriate premiums measure of its tax. Nothing in ERISA requires such an inane result.

II

IF CERTIORARI WERE GRANTED, ADDITIONAL ISSUES SHOULD BE CONSIDERED REGARDING THE ERISA PREEMPTION CLAUSE, STANDING, AND THE TAX INJUNCTION ACT

A. Introduction

Respondents are not independently seeking review by this Court of the Court of Appeals' decision. However, if GM's petition were to be granted there should be review of several additional issues, which were decided by the Court of Appeal in petitioners' favor before judgment was rendered for respondents.

B. The Application of the California Insurance Tax Is Not Pre-empted by the ERISA Pre-emption Clause

Before its determinative holding on the ERISA saving clause, the Court of Appeals' opinion concluded that California's application of its insurance tax "'relate[s] to' employee benefit plans, thereby invoking ERISA's preemption clause, 29 U.S.C. § 1144(a)." 815 F.2d at 1309-1310, Pet. 10a-12a. That opinion was filed on April 29, 1987. On June 1, 1987, this Court further clarified the scope of the ERISA pre-emption clause in *Fort Halifax Packing Co., Inc. v. Coyne*, ____ U.S. ____, 107 S.Ct. 2211 (1987). Under *Fort Halifax* it is clear that the pre-emption clause is not applicable in this case.

Fort Halifax holds that the pre-emption clause does not apply to all "state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit *plans*' ". 107 S.Ct. at 2215 (emphasis by the Court). Therefore, although in *Fort Halifax* the State of Maine was requiring a certain type of employee benefit, this Court held that requirement was not subject to the ERISA pre-emption clause "because the statute neither establishes, nor requires an employer to maintain, an employee welfare benefit

'plan' under that federal statute." *Id.* (Footnote omitted.) Even though the words "relate to" should be construed expansively (*id.*), "[n]othing in our case law . . . supports [the] position that the word 'plan' should in effect be read out of the statute." *Id.* at 2216.

As shown above (pp. 10-13), the state practice challenged here by GM is a mere computational reference to dollar amounts of insurance claims to be paid out under certain circumstances pursuant to the terms of an insurance policy issued by the Metropolitan Life Insurance Company.[9] In making this reference California is not dictating the terms of any ERISA plan, as New York was attempting in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); California is not even referring to the terms of any ERISA plan, for no ERISA plan containing the claims payment provisions at issue was ever submitted by petitioners to the California authorities or to the courts below in this case. Nor is California dictating the content of any insurance policy benefit terms, an action which would "relate to" an underlying ERISA plan under the pre-emption clause but be saved by the saving clause. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739, 744. Under the pre-emption clause test as most recently clarified in *Fort Halifax*, California's challenged action does not directly or indirectly establish, dictate the contents of, or require the maintenance of any particular *plan*. Even if California's computational reference to certain dollar amounts of insur-

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[9] Petitioners do not challenge California's ability to impose an insurance tax on Metropolitan "even though the costs of the tax are passed through by the insurer to an ERISA plan." Pet. 17. This is reasonable, since California can directly regulate the rates of the premiums charged by the insurance company without "relat[ing] to" any underlying ERISA plan. See *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 741, 728 & n. 2. In contrast, some of the amici supporting petitioners take the quite unreasonable approach that ERISA would pre-empt any state tax whose cost might be passed down indirectly to the employers in an ERISA plan. Such an approach would render all such business of insurance tax free, a result which would be directly contrary to the McCarran-Ferguson Act and which would find no support in the terms or legislative history of ERISA.

ance claims somehow "relates to" certain ERISA plan *benefits*, that reference does not "relate to" ERISA benefit *plans* under the ERISA pre-emption clause.[10]

"The presumption is against pre-emption . . . ." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741. "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' *Allessi v. Raybestos-Manhattan, Inc.*, 451 U.S., at 522, 101 S.Ct., at 1905 (1981). The argument that ERISA pre-empts state laws relating to certain employee benefits, rather than to employee benefit *plans*, is refuted by the express language of the statute, the purposes of the pre-emption provision, and the regulatory focus of ERISA as a whole." *Fort Halifax Packing Co., Inc. v. Coyne*, 107 S.Ct. at 2221.

C. Either the Nontaxpayer Petitioners Have No Standing, or This Action to Enjoin the Collection of a California Tax Is Barred by the Federal Tax Injunction Act

1. Introduction

In contractual agreements separate from the insurance policy documents, both petitioners agreed to reimburse Metropolitan for any taxes paid by Metropolitan which are of the type at issue in this case; in turn, Metropolitan agreed to seek relief from such taxes through all appropriate legal procedures. A. Exc. 1675-1676, 1850-1851. Petitioners have relied on these voluntary agreements as a direct link which provides them standing to sue state

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[10] The *Fort Halifax* recognition of the significance of the use of the term "plan" in the pre-emption clause fully comports with the limitation of ERISA pre-emption which is built into the pre-emption section's definition of the word "State." As noted in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), "For purposes of the pre-emption provision, ERISA defines the term 'State' to include: 'a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans covered by this subchapter.' 29 U.S.C. § 1144(c)(2) (emphasis added)." In no way do the challenged California computational procedures "regulate, directly or indirectly, the *terms and conditions*" of any ERISA plans. (Emphasis added.)

officials for an injunction of the tax, but then petitioners have argued that these same agreements are too tenuous to bring petitioners under the federal Tax Injunction Act's prohibition of injunctions of the "assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of the State." 28 U.S.C. § 1341. Petitioners cannot have it both ways. For that matter, petitioners cannot have it either way.

2. Petitioners Have No Standing

The Court of Appeals' conclusion that petitioners had standing was based in large part on section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). A statute cannot confer standing if there is no standing under the federal Constitution. *Valley Forge College v. Americans United*, 454 U.S. 464, 488 n. 24 (1982). "The requirement of standing . . . has a core component derived directly from the Constitution. A plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen v. Wright*, 468 U.S. 737, 751 (1984).

In *Alien v. Wright* this Court, noting that "the standing inquiry must be answered by reference to the Art. III notion that federal courts may exercise power only 'in the last resort, and as a necessity,'" *id.* at 752, held that the plaintiffs therein could not assert their second claim of injury "because the injury alleged is not fairly traceable to the government conduct [plaintiffs] challenge as unlawful." *Id.* at 757 (footnote omitted). In the words of this Court, "The links in the chain of causation between the challenged Government conduct and the asserted injury are far too weak for the chain as a whole to sustain [plaintiffs'] standing." *Id.* at 759.

In the case at bar petitioners, by entering into the above contract with Metropolitan, purportedly have forged their own link to connect the challenged governmental action to the alleged injury they have directed upon themselves. That is like a man who purposely grips a lightning rod in a thunderstorm and then curses the heavens for his misfortune after the bolt strikes the rod. The disputed tax in this case was assessed solely against Metropolitan.

Petitioners have voluntarily contracted with Metropolitan to reimburse Metropolitan for the disputed tax. This voluntary assumption of liability to Metropolitan cannot create standing to sue the state, particularly on an issue that would be foreclosed to Metropolitan itself in the Federal courts.

3. The Tax Injunction Act Bars Relief

If petitioners' agreements to reimburse Metropolitan somehow have sufficient substance to create standing for petitioners to sue respondents, then the remedies provided by those same agreements should be considered in determining whether petitioners have a "plain, speedy and efficient remedy" in the California courts. If petitioners have such a plain, speedy and efficient remedy, the relief in this action is clearly barred by the language of the Tax Injunction Act, 28 U.S.C. § 1341.[11]

As noted above, petitioners' agreements with Metropolitan impose upon Metropolitan the duty to "seek relief from such premium taxes through all appropriate legal procedures. . . ." A. Exc. 1675, 1850. The record also shows that Metropolitan has such lawsuits pending in California courts. A. Exc. 83-512. Under the agreements petitioners have access to the California courts to protect petitioners from any failure by Metropolitan to fulfill its contractual obligations. In other words, GM could be made whole by suit to require Metropolitan to pursue its remedies and, if Metropolitan failed to perform, to obtain damages from Metropolitan under the GM/Metropolitan contract. This remedy, which fully mirrors the reimbursement obligations assumed by petitioners under their contracts, is a plain, speedy and efficient remedy sufficient to require application of the Tax Injunction Act.

As pointed out by the Court of Appeals, respondents recognize that, since petitioners themselves have not paid the taxes, peti-

[11] The Court of Appeals correctly has concluded that "ERISA actions are subject to the Tax Injunction Act." 815 F.2d at 1308, Pet. 9a, citing *Ashton v. Cory*, 780 F.2d 816, 821-22 (9th Cir. 1986). In addition to barring injunctive relief, the Act also prohibits declaratory relief invalidating state taxes. *California v. Grace Brethren Church*, 457 U.S. 393, 408 (1982).

tioners cannot sue the state or its officials in the California courts to challenge their collection. But petitioners' lack of remedy against the *state* does not mean they come within the Tax Injunction Act's exception. In order to accomodate judicial concerns and to "be faithful to the congressional intent 'to limit drastically' federal-court interference with state tax systems, [this Court] must construe narrowly the 'plain, speedy and efficient' exception to the Tax Injunction Act." *California v. Grace Brethren Church*, 457 U.S. 393, 413. There is no requirement in the Tax Injunction Act that the state remedy must be directly against the state if the plaintiff's burden is not imposed directly by the state. As to taxpayers themselves, this Court has held that the California tax refund procedures satisfy the requirements of the Tax Injunction Act. *Id.* at 413-417. Since Metropolitan clearly could not seek injunctive relief in federal court, and since the scope of the California remedy available to petitioners is fully proportionate to the reimbursement obligations they have assumed, petitioners should not be permitted to subvert the purpose of the Tax Injunction Act by seeking in their names the same federal relief which is so clearly barred to Metropolitan.

CONCLUSION

What is California doing that is the true target of petitioners' attack? In applying the California Insurance Tax to the California insurance business of Metropolitan, California merely takes the substance of Metropolitan's insurance policy as it presently stands and applies the pre-ERISA established rules of California insurance law, which rules are fully protected by the McCarran-Ferguson Act. Since Metropolitan, under its policy, provides the insured employees with insurance coverage for all of the benefits that policy provides, and since California, with its challenged reference to certain policy claims amounts, is making that reference solely for computational use in determining a dollar value for labor premiums paid by the insured employees, there is no prohibition in ERISA which eclipses the McCarran-Ferguson protection afforded to California.

California's application of its Insurance Tax does not restrict the range of insurance options open to ERISA fiduciaries. If, as in

this case, they choose insurance wherein an insurance company provides insured employees with insured coverage as to all claims; they should not be surprised when that insurance company is taxed accordingly. Petitioners' arguments as to the supposedly dire prospective effects of California's actions are directed at phantoms not present here: those arguments, as well as the arguments of each amicus brief filed in support of petitioners' position[12], are based on alleged circumstances of "self insurance" and "taxing of ERISA benefits" that simply are not present in this case. Those arguments should be made only when a plan truly is not fully insured and when a state truly is taxing ERISA benefits. That is not this case.

For the reasons given above, and because of the lack of any conflict among the Circuit Courts of Appeals, it is respectfully submitted that the petition for a writ of certiorari should be denied.

Dated: February 11, 1988

Respectfully submitted,

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[12] Petitioners' application to this Court of October 30, 1987, sought an extension in order to "allow the Department of Labor more time to develop its view of the case" in order to reach a decision as to whether to file a brief in support of the petition. The time was extended, and the Department of Labor did not file such a brief.

APPENDIX A

29 U.S.C. § 1144 (ERISA § 514):

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii),

individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056 (d)(3)(B)(i) of this title).

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

15 U.S.C. §§ 1011-1015 (McCarran-Ferguson Act)

§ 1011.

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relates to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, that after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade

Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

§ 1013.

(a) Until June 30, 1948, the Act of July 2, 1980, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

§ 1014.

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

§ 1015.

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam and the District of Columbia.

28 U.S.C. § 1341 (Tax Injunction Act):

§ 1341.

The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State.

California Constitution, Art. XIII, § 28 (in pertinent part):

SEC. 28. (a) "Insurer," as used in this section, includes insurance companies or associations and reciprocal or interinsurance exchanges together with their corporate or other attorneys in fact considered as a single unit, and the State Compensation Insurance Fund. As used in this paragraph, "companies" includes persons, partnerships, joint stock associations, companies and corporations.

(b) An annual tax is hereby imposed on each insurer doing business in this state on the base, at the rates, and subject to the deductions from the tax hereinafter specified.

(c) In the case of an insurer not transacting title insurance in this state, the "basis of the annual tax" is, in respect to each year, the amount of gross premiums, less return premiums, received in such year by such insurer upon its business done in this state, other than premiums received for reinsurance and for ocean marine insurance.

* * *

(d) The rate of the tax to be applied to the basis of the annual tax in respect to each year is 2.35 percent.

* * *

(h) The taxes provided for by this section shall be assessed by the State Board of Equalization.

(i) The Legislature, a majority of all the members elected to each of the two houses voting in favor thereof, may by law change the rate or rates of taxes herein imposed upon insurers.

(j) This section is not intended to and does not change the law as it has previously existed with respect to the meaning of the words "gross premiums, less return premiums, received" as used in this article.

California Revenue & Taxation Code, §§ 12201, 12221:

§ 12201.

Every insurer doing business in this State shall annually pay to the State a tax on the bases, at the rates, and subject to the

deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

§ 12221.

In the case of an insurer not transacting title insurance in this State, the basis of the tax is, in respect to each year, the amount of gross premiums, less return premiums, received in such year by such insurer upon its business done in this State. "Gross premiums" do not include premiums received for reinsurance and for ocean marine insurance. Gross premiums of reciprocal or interinsurance exchanges shall be determined as provided in Section 1530 of the Insurance Code. For purposes of the tax imposed by this chapter, "gross premiums" shall be deemed to include home protection contract fees defined in Section 12740 of the Insurance Code.

APPENDIX B

[GROUP POLICY FORM OF THE METROPOLITAN LIFE INSURANCE COMPANY]

(Herein Called the Insurance Company)

Group Policy No. Specimen issued to

A. B. C. Company
(Herein Called the Employer)

In consideration of the payment by the Employer of the initial premium and of the payment hereafter by the Employer, during the continuance of this Policy, of all premiums when they fall due as hereinafter provided, the Insurance Company promises to make the payments herein provided, with respect to the Employees Insured hereunder, in accordance with and subject to the provisions of this Policy.

The provisions hereinafter contained are part of this Policy as fully as if recited over the signatures hereto affixed.

This Policy is issued for an initial period commencing with the date of issue and ending with the day immediately preceding January 1, 1959.

IN WITNESS WHEREOF, the Metropolitan Life Insurance Company has caused this Policy to be executed this third day of January 1958, to take effect as of the first day of January 1958, which last date is the date of issue hereof.

Secretary President

Registrar

Group Policy

Accident and Sickness Insurance (Weekly Benefit)
Insurance for Death or Dismemberment by
Accidental Means
Hospital Expense Insurance
Surgical Operation Insurance

Section 1. DEFINITIONS.—

(A) "Employee" means a full-time employee directly employed and compensated for services by the Employer.

(B) "Dependent" means (1) an Employee's wife, or (2) any unmarried child over fourteen days of age and under nineteen years of age of a male Employee, of a widowed female Employee, or of a female Employee whose husband is not an Employee, excluding in any case, (a) any person who is eligible for insurance as an Employee, (b) any person residing outside the United States and Canada, and (c), as to the Contributory Insurance, any person whose evidence of good health, furnished in accordance with the provisions of Section 3, is not accepted by the Insurance Company as satisfactory. The term "child" includes any legally adopted child, any stepchild who resides in the Employee's household, and any chi'd supported solely by the Employee and permanently residing in the household of which the Employee is the head.

(C) "Personal Insurance" means insurance providing benefits payable to an Employee on account of the happening of a specified event to the Employee.

(D) "Dependent Insurance" means insurance providing benefits payable to an Employee on account of the happening of a specified event to any of his Dependents.

(E) "Physician" or "surgeon" means a person legally licensed to practice medicine.

(F) "Hospital" means an institution operated for the care and treatment of sicknesses and injuries and having facilities for diagnostic, 24-hour nursing service, and, except in the case of a hospital primarily concerned with the treatment of chronic diseases, major surgery. The term "hospital" shall not include an establishment that is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, or a hotel.

(G) "Non-occupational injury" means any injury not arising out of or in the course of any employment for wage or profit.

(H) "Non-occupational sickness" means any sickness not entitling the person who has contracted the sickness to benefits under any workmen's compensation or occupational disease law.

(I) "Renewal date" means any January 1st following the date of issue of this Policy.

(J) "Due date" means the first day of any calendar month which begins after the date of issue of this Policy.

Section 2. ELIGIBILITY OF EMPLOYEES.—

Each employee employed on or prior to the date of issue of this Policy becomes eligible for Personal Insurance on the date of issue of this Policy. Each Employee employed subsequent to the date of issue of this Policy shall become eligible for Personal Insurance on the day immediately following the date of completion of three months of continuous service.

Each Employee shall become eligible for Dependent Insurance on the date he becomes eligible for Personal Insurance or the date the first person becomes a Dependent of such Employee, whichever date is later.

Section 3. EFFECTIVE DATES OF INSURANCE.—

(A) NON-CONTRIBUTORY INSURANCE (IF ANY)

(1) The Non-Contributory Personal Insurance on any Employee shall become effective on the date he becomes eligible for such insurance, provided he is then actively at work. The Personal Insurance on any Employee not actively at work on the day when his Personal Insurance would otherwise become effective shall become effective on the date of his return to active work.

(2) The Non-Contributory Dependent Insurance on any Employee shall become effective, with respect to those persons who are then Dependents of such Employee, on the date he becomes eligible for such Insurance, or on the effective date of his Personal Insurance, if later.

(3) The Non-Contributory Dependent Insurance with respect to any person who becomes a Dependent of an Employee while such Employee is Insured for Non-Contributory Dependent In-

surance shall become effective on the date such person becomes a Dependent of such Employee.

(B) CONTRIBUTORY INSURANCE (IF ANY)

(1) An Employee may become insured for Contributory Personal Insurance only by making written request to the Employer for such insurance on forms furnished by the Insurance Company.

(2) The Personal Insurance on any Employee who makes such request on or before the date he becomes eligible for such insurance shall become effective on the date he becomes eligible for such insurance, provided he is then actively at work.

(3) The Personal Insurance on any Employee who makes such request after the date he becomes eligible for such insurance and on or before the thirty-first day following the date he becomes eligible for such insurance, or on or before the thirty-first day following the date of his return to active work if he is not actively at work on the date he becomes eligible for such insurance, shall become effective, provided he is then actively at work, on the date of such request.

(4) Any Employee making such request after such thirty-first day and any Employee requesting reinstatement of his Personal Insurance after his Personal Insurance has ceased pursuant to Section 4 because of his failure to make the required contribution, must furnish at his own expense evidence of his insurability satisfactory to the Insurance Company before his Personal Insurance may become effective. The Personal Insurance on such Employee shall become effective, provided such Employee is then actively at work, on the first day of the calendar month next following the date the Insurance Company accepts such evidence of insurability as satisfactory.

(5) The Personal Insurance on any Employee not actively at work on the date when his Personal Insurance would otherwise become effective shall become effective on the dated of his return to active work.

(6) An Employee may become insured for Contributory Dependent Insurance only by making written request to the Em-

ployer for such insurance on forms furnished by the Insurance Company.

(7) The Dependent Insurance on any Employee who makes such request on or before the date he becomes eligible for such insurance shall become effective with respect to those persons who are then Dependents of such Employee, on the date he becomes eligible for such insurance, or on the effective date of such Employee's Personal Insurance, if later.

(8) The Dependent Insurance on any Employee who makes such request after the date he becomes eligible for such insurance and on or before the thirty-first day following the date he becomes eligible for such insurance, or on or before the thirty-first day following the date of his return to active work if he is not actively at work on the date he becomes eligible for such insurance, shall become effective, with respect to those persons who are then Dependents of such Employee, on the first day of the calendar month following the date of such request, or on the effective date of the Employee's Personal Insurance, if later.

(9) Any Employee making such request after such thirty-first day and any Employee requesting reinstatement of his Dependent Insurance after his Dependent Insurance has ceased pursuant to Section 4 because of his failure to make the required contributions, must furnish at his own expense evidence satisfactory to the Insurance Company of the good health of each person who is a Dependent of such Employee on the date of such request before the Dependent Insurance with respect to such Dependent may become effective. Any such insurance shall become effective with respect to each such Dependent whose evidence of good health is accepted by the Insurance Company as satisfactory, on the first day of the calendar month following the date of such acceptance by the Insurance Company, or on the effective date of the Employee's Personal Insurance, if later. In the event that the evidence of good health of any such person is not accepted by the Insurance Company as satisfactory, such person shall not, for the purposes of insurance hereunder, be deemed a Dependent and no Dependent Insurance shall be provided to such person.

(10) The Contributory Dependent Insurance with respect to any person who becomes a Dependent of an Employee while such Employee is insured for Contributory Dependent Insurance shall become effective on the date such person becomes a Dependent of such Employee.

(11) An Employee employed in Plant K may make written request for either (a) all types of insurance provided hereunder, or (b) all types of insurance provided hereunder exclusive of Surgical Operation Insurance. If any such Employee becomes insured for insurance as specified in (b) and subsequently desires to become insured for Surgical Operation Insurance, all the provisions of this subsection (B) shall be separately applicable with respect to the Surgical Operation Insurance.

Section 4. Cessation of Insurance.—

(1) The Personal Insurance and Dependent Insurance on any Employee insured hereunder shall automatically cease on whichever of the following dates first occurs:

(a) the last day of the calendar month in which termination of his employment occurs.

(b) the date of discontinuance of this Policy.

(2) If the Employee fails to make any contribution, as required, to the cost of his Contributory Personal Insurance, his Contributory Personal Insurance and Contributory Dependent Insurance shall automatically cease on the date of expiration of the last period for which the Employee made the required contribution.

(3) If the Employee fails to make any contribution, as required, to the cost of his Contributory Dependent Insurance, his Contributory Personal Insurance and Contributory Dependent Insurance shall automatically cease on the date of expiration of the last period for which the Employee made the required contribution.

(4) The Dependent Insurance on account of any Dependent shall automatically cease on the day immediately preceding the date such person ceases to be a Dependent of the Employee.

(5) Termination of employment, for the purposes of insurance hereunder, means cessation of active work as an Employee as defined in Section 1 hereof, except that in case of the absence of an Employee from active work because of sickness or injury, temporary lay-off or leave of absence, his employment may, for the purposes of his insurance hereunder, be deemed to continue until terminated by the Employer or by an act of the Employee but in the case of temporary lay-off or leave of absence, not beyond the expiration of a period of two months following the date such lay-off or leave of absence commenced.

(6) When an Employee is absent from active work and his employment is deemed to continue until terminated by the Employer or by an act of the Employee, employment shall be considered terminated by the Employer, if the Employer notifies the Insurance Company that the Employee is not to be included as an insured Employee, or if the Employer discontinues premium payment on account of such Employee.

Section 5. TYPES OF INSURANCE.—This Policy provides the following types of insurance in accordance with the provisions hereof and of the forms specified, which forms are part of this Policy.

Type of Insurance	Form
Accident and Sickness Insurance	G.2230-4
Insurance for Death or Dismemberment by Accidental Means	G.2235-4
Hospital Expense Insurance Personal and Dependent Benefits	G.2240-4
Surgical Operation Insurance Personal and Dependent Benefits	G.2244-4

Section 6. COMPUTATION AND PAYMENT OF PREMIUMS; GRACE PERIOD.—

(1) The premiums due on and after the date of issue of this Policy for the insurance provided hereunder shall be determined and shall be payable in accordance with the following paragraphs.

(2) The initial premium is due on the date of issue of this Policy and subsequent premiums shall be due on each due date thereafter.

(3) The initial premium rates for the insurance provided hereunder are shown in the respective riders attached hereto. The Insurance Company may change any or all of such premium rates (a) on the first renewal date of this Policy and on any due date thereafter, or (b) whenever the terms of this Policy are changed, provided that in the case of any increase in the premium rates, except when the terms of the Policy are changed, the Insurance Company shall deliver to the Employer written notice of such increase at least thirty-one days prior to the date such increase is to become effective.

(4) The initial premium due on the date of issue of this Policy and the premium due on any due date after the date of issue of this Policy shall be the aggregate of the premiums for the insurance then in force, determined on the basis of the premium rates then in effect for the respective types of insurance, subject to premium adjustments, if any.

(5) In the computation of the aggregate premium due under this Policy on any due date, the Inusrance Company may use any equitable method which is mutually agreeable to the Employer and the Insurance Company.

(6) Premium adjustments involving return of unearned premiums to the Employer shall be limited to the period of twelve months immediately preceding the date of receipt by the Insurance Company of evidence that such adjustments should be made.

(7) On written request of the Employer, approved by the Insurance Company, premium payments may, if not then so payable, be changed at any due date of this Policy so as to be payable annually, semi-annually, quarterly, or monthly.

(8) All premiums falling due under this Policy, including adjustments thereof, if any, are payable by the Employer, on or before their respective due dates, directly to the Insurance Company at its Home Office or one of its Head Offices. The payment of any premium shall not maintain the insurance under this Policy in force beyond the day immediately preceding the next due date, except as provided in the next paragraph.

(9) Grace Period.—A grace period of thirty-one days will be granted for the payment of premiums accruing after the first premium, during which grace period this Policy shall continue in force, but the Employer shall be liable to the Insurance Company for the payment of the premium accruing for the period the Policy continues in force.

(10) If the Employer fails to pay any premium within the grace period, this Policy shall be discontinued on the last day of such grace period, except that if written notice is given by the Employer to the Insurance Company prior to the expiration of the grace period that this Policy is to be discontinued before the expiration of the grace period, this Policy shall be discontinued as of the date of receipt of such written notice by the Insurance Company or the date specified by the Employer for such discontinuance, whichever date is later, and the Employer shall be liable to the Insurance Company for the payment of the pro-rata premium for the period commencing with the last due date and ending with such date of discontinuance.

Section 7. CERTIFICATES.—The Insurance Company will issue to the Employer, for delivery to each Employer insured hereunder, an individual certificate which shall state the insurance to which such Employee is entitled under this Policy and to whom benefits are payable, and which shall summarize the provisions of this Policy principally affecting the Employee. The word "certificate" as used in this Policy includes certificate riders and certificate supplements, if any.

Section 8. ASSIGNMENT.—The Employee's certificate is non-assignable and the insurance and benefits are non-assignable prior to a loss.

Section 9. RECORDS; INFORMATION TO BE FURNISHED.—The Insurance Company shall maintain records from which may be determined at all times the names of all Employees insured hereunder and the amount of insurance in force on each of such Employees, together with the date when any insurance became effective and the effective date of any increase or decrease in amount of insurance. Such records may, with the

consent of the Insurance Company, be maintained by the Employer.

The Employer and the Employees shall furnish to the Insurance Company all information which the Insurance Company may reasonably require with regard to any matters pertaining to the insurance under this Policy. The Employer agrees to allow the Insurance Company to inspect all documents, books, and records of the Employer which may have a bearing on the insurance or premiums under this Policy.

Section 10. PARTICIPATION; DIVIDENDS.—This Policy is a participating contract and the Insurance Company shall determine annually the dividend, if any, to which this Policy may be entitled. Any such dividend shall be paid in cash to the Employer or, upon written request by the Employer, shall be applied toward the payment of premiums. The Employer may apply any dividend to reduce the Employer's cost of this Policy, except that an amount equal to the excess, if any, of the Employee's aggregate contributions toward the cost of the insurance provided hereunder over the net cost of such insurance shall be distributed or applied by the Employer for the sole benefit of the Employees.

Section 11. RENEWAL PRIVILEGE.—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, provided that the Insurance Company may decline to renew this Policy on any renewal date (a) if the number of Employees then insured for Contributory Insurance is less than 75% of the number of Employees eligible for such insurance, (b) if the number of Employees then insured for Non-Contributory Insurance is less than the total number of Employees eligible for such insurance, or (c) if the number of Employees then insured hereunder is less than twenty-five. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.

Section 12. ENTIRE CONTRACT; CHANGES.—This Policy and the application of the Employer constitute the entire

contract between the parties, and any statement made by the Employer or by any Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Employer, except a fraudulent misstatement, be used at all to void this Policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Employee eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the Policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by an executive officer of the Insurance Company. No agent has authority to change this Policy or to waive any of its provisions.

Section 13. ADDITIONAL PROVISIONS.—This Policy is not in lieu of and does not affect any requirement for coverage by workmen's compensation insurance.

APPLICATION TO THE METROPOLITAN LIFE INSURANCE COMPANY FOR GROUP INSURANCE

A.B.C. COMPANY
(*Name of Employer*)
100 Main Street, Doeville, California
(*Address where Policy is to be delivered and from which premiums are to be paid*)

The word "Employee", as used herein, means a full-time employee directly employed and compensated for services by the Employer.

Forms of Group Insurance desired are:

	For Employees Only	For Employees and Dependents
Life Insurance	☐	☐
Accident and Health Insurance	☒	☐
Insurance for Death or Dismemberment by Accidental Means	☒	☐
Hospital Expense Insurance	☐	☒
Surgical Operations Insurance	☐	☒
Supplementary Hospital Benefits for Physicians' Attendance	☐	☐
Insurance for Physicians' Attendance Expense While in Hospital	☐	☐
Medical Expense Insurance	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Premiums will be paid Monthly ☒, _____ly ☐. Advance payment of $100.00 accompanies this application.

It is agreed that:

(a) The conditions of eligibility for insurance, the amounts of insurance, the conditions under which insurance will be payable and other contractual terms shall be in accordance with the Policy (or Policies) issued.

(b) The Group Policy (or Policies) shall become effective provided:

(1) This application is accepted by the Metropolitan Life Insurance Company at its Home Office or one of its Head Offices.

(2) At least 25 Employees are to be insured on the date of issue thereof.

(3) If the Employees are to contribute toward the cost, at least 75% of all eligible Employees make written requests for insurance thereunder and if insurance for Dependents is applied for and Employees are required to contribute to the cost thereof, at least 75% of all Employees eligible for such insurance make written request therefor, and

(4) An amount equal to the initial premium as estimated by the Insurance Company has been received by the Insurance Company.

(c) The Employer shall furnish the Insurance Company each month with the necessary particulars concerning employees to be insured on or subsequent to the date of issue of the Policy (or Policies), and on employees whose insurance is to be changed or discontinued.

(d) The Group Policy (or Policies) applied for will not be in addition to nor replace any other insurance on the Group or similar plan except as follows: x x x x x x

Dated at Doeville, California this first day of January, 1958

A.B.C. COMPANY
(*Employer*)

JAMES SMITH (*Witness*) By RICHARD ROE PRESIDENT (*Title*)

COPY OF EMPLOYER'S APPLICATION
ATTACHED HERETO

NOTICES TO POLICYHOLDERS

PRIVILEGE OF VOTING FOR DIRECTORS. An election of Directors of the Insurance Company is held in New York on the second Tuesday in April of every odd-numbered year. The holder of this Policy (the Employer), after one year from its date of issue, while it remains in force, will have a right to vote either in person or by proxy or by mail. For particulars as to how to vote, apply to the Secretary, 1 Madison Avenue, New York, N.Y.

NOMINATIONS FOR DIRECTORS. Section 198 of the New York Insurance Law requires the Board of Directors to nominate candidates described as the "Administration Ticket" and permits groups of policyholders to make other nominations not less than five months prior to the election.

METROPOLITAN LIFE INSURANCE COMPANY

HOME OFFICE	HEAD OFFICES	
1 Madison Avenue	600 Stockton Street	180 Wellington Street
New York, New York	San Francisco, California	Ottawa, Ontario, Canada

Countersigned January 3, 1958

By Richard Roe
Licensed Agent

Employer: A. B. C. Company

Group Policy No. Specimen Effective Date of Rider: January 1, 1958

Group Accident and Sickness Insurance Rider
Personal Benefits

Issued By

Metropolitan Life Insurance Company
(Herein called the Insurance Company)

Section H-1. Insuring Clause.—Upon receipt by the Insurance Company of notice and due proof, as required herein, that any Employee while insured hereunder shall have become wholly and continuously disabled so as to be prevented from performing any and every duty of his occupation as a result of non-occupational injury or non-occupational sickness and that during the period of such disability such Employee shall have been under treatment therefor by a physician or surgeon, the Insurance Company shall pay to such disabled Employee, subject to the terms and limitations hereof, the Weekly Benefits applicable to him in accordance with Section H-2 hereof, during the period the Employee is so disabled and under such treatment, provided that

(i) in no case shall such Weekly Benefits be payable for the Waiting Period, and

(ii) in no case shall such Weekly Benefits be payable for more than the Maximum Benefit Period.

The Waiting Period and Maximum Benefit Period referred to above shall be applicable to any one continuous period of disability whether from one or more causes.

Successive periods of disability due to the same or related cause or causes shall be considered one continuous period of disability unless, between such periods of disability, the Employee was actively at work as an Employee for at least three months.

No payment shall be made for any period during which the Employee engages in any gainful occupation.

For disability caused by any one pregnancy or resulting childbirth or complications, not more than six weeks' benefits shall be paid; provided that if the date the Employee became insured is on or subsequent to February 2, 1958, no benefits shall be paid for such diability commencing within nine months after the date she became insured unless affirmative proof is submitted to the Insurance Company that the pregnancy commenced after the date she became insured.

For all periods of disability commencing on or after the Employee's sixtieth birthday and within any twelve consecutive months, Weekly Benefits shall not be payable for more than the Maximum Benefit Period applicable to the Employee.

The Accident and Sickness Insurance on any Employee shall automatically cease upon the expiration of the Maximum Benefit Period applicable to him. Such insurance may be reinstated only if and when the Employee returns to active work as an Employee on full time.

Section H-2. SCHEDULE OF INSURANCE AND INITIAL PREMIUM RATES.—The insurance applicable to any Employee shall be in accordance with the schedule set forth below and any change in accordance with such schedule shall become effective, provided the Employee is then actively at work, on the date of change in the Employee's classification; if the Employee is not then actively at work, such change shall become effective on the date of his return to active work.

	Weekly Benefit	Waiting Period for Disability Due to Injury	Waiting Period for Disability Due to Sickness	Maximum Benefit Period	Initial Monthly Premium Rate per Employee
		NON-CONTRIBUTORY INSURANCE			
All Employees	$10.00	No Waiting Peirod	First Seven Days*	Twenty-six Weeks	$0.66
		CONTRIBUTORY INSURANCE			
Employees with basis annual rate of earnings (as determined by the Employer) of:					
Less than $3,000.00	20.00				1.32
$3,000.00 but less than $4,000.00	30.00	No Waiting Period	First Seven Days*	Thirteen Weeks	1.98
4,000.00 but less than 6,000.00	40.00				2.64
6,000.00 but less than 8,000.00	50.00				3.30
8,000.00 or more	60.00				3.96

* or the period of disability prior to confinement in a hospital as a registered bed patient if such confinement commences prior to the expiration of the Waiting Period otherwise applicable.

No Employee shall contribute to the cost of his Contributory Insurance more than the premium for such insurance. No Employee shall contribute to the cost of his Non-Contributory Insurance.

Section H-3. NOTICE OF CLAIM.—Written notice of claim must be given to the Insurance Company within twenty days after the occurrence or commencement of any loss covered by this Rider, or as soon thereafter as is reasonably possible.

Section H-4. CLAIM FORMS.—The Insurance Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Rider as to proof of loss upon submitting, within the time fixed in this Rider for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Section H-5. PROOFS OF LOSS.—Written proof of loss for which a claim for Weekly Benefits is made must be furnished to the Insurance Company within ninety days after the termination of the period for which the Insurance Company is liable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Employee, later than one year from the time proof is otherwise required.

Section H-6. TIME OF PAYMENT OF CLAIM.—Subject to due written proof of loss, all accrued indemnity for loss for which this Rider provides Weekly Benefits will be paid to the insured Employee weekly and any balance remaining unpaid at the termination of the period of liability will be paid immediately upon receipt of due written proof.

Section H-7. PHYSICAL EXAMINATION.—The Insurance Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during pendency of a claim hereunder.

Section H-8. LEGAL ACTIONS.—No action at law or in equity shall be brought to recover on this Rider prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Rider. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

IN WITNESS WHEREOF, the Metropolitan Life Insurance Company has caused this Rider to be executed to take effect as of the effective date of the Rider as indicated on the first page hereof.

Secretary President

[The "Group Insurance for Death or Dismemberment By Accidental Means Rider (Personal Benefits)" and the "Group Hospital Expense Insurance Rider (Personal and Dependent Benefits)", comprising pages 1219 through 1227 of Appellants' Excerpt of Record on file with the Court of Appeals, is deleted for purposes of this Appendix.]

Employer: A. B. C. Company

Group Policy No. Specimen Effective Date of Rider: January 1, 1958

Group Surgical Operation Insurance Rider
Personal and Dependent Benefits

Issued By

Metropolitan Life Insurance Company
(Herein called the Insurance Company)

Section S-1. INSURING CLAUSE.—Upon receipt of due proof, as required herein, that any Employee, while insured hereunder for Surgical Operation Insurance on his own account, or any Dependent of an Employee, while such Employee is insured hereunder for Surgical Operation Insurance on account of such Dependent, shall have undergone a surgical operation as a result of non-occupational injury or non-occupational sickness, the Insurance Company shall pay, subject to the terms and limitations hereof, an amount equal to the actual surgical fee charged for such surgical operation, provided (1) that such surgical operation was recommended and performed by a physician or surgeon, and (2) that the amount of such payment shall in no event exceed the maximum payment for such surgical operation determined in accordance with Section S-3 hereof.

If two or more surgical operations are performed upon an Employee or Dependent at the same time, or if two or more surgical operations due to the same or related cause or causes are performed upon an Employee or Dependent at different times, the total payment hereunder for all such operations shall not exceed the Maximum Surgical Operation Benefit in force hereunder on account of such Employee or Dependent who has undergone such operations, as determined by Section S-2 hereof, subject to any limitations set forth in Section S-3 hereof. Operations performed on an Employee and separated by a period of at least three months of active work as Employee, or operations performed on a Dependent and separated by a period of at least three months of normal activity by the Dependent, shall not be considered due to the same or related cause or causes.

In the case of a female Employee becoming insured on or subsequent to February 2, 1958, no payment shall be made for a surgical operation performed on the Employee within nine months after the date the Employee became insured if the surgical operation is caused by pregnancy or resulting childbirth or complications unless affirmative proof is submitted to the Insurance Company that the pregnancy commenced after the date the Employee became insured.

No payment shall be made for a surgical operation performed on a Dependent within nine months after the date the Employee became insured on account of such Dependent if the surgical operation is caused by pregnancy or resulting childbirth or complications, unless affirmative proof is submitted to the Insurance Company that the pregnancy commenced after the date the Employee became insured on account of the Dependent.

Benefits hereunder are not payable for any surgical operation which is or may be obtained without cost to a person covered hereunder, in accordance with laws or regulations of any government. If a charge is made to any such person which he is legally required to pay, any benefits hereunder will be computed in accordance with the provisions hereof, taking into account only such charge. "Any government" includes the Federal, State, Provincial or local government or any political subdivision thereof, of the United States or Canada.

An Employee's Surgical Operation Insurance on his own account shall automatically cease on the date he becomes entitled to the Maximum Surgical Operation Benefit applicable to him. Such insurance may be reinstated only if and when the Employee returns to active work as an Employee on full time.

An Employee's Surgical Operation Insurance on account of any Dependent shall automatically cease on the date the Employee becomes entitled to the Maximum Surgical Operation Benefit applicable to such Dependent. Such insurance may be reinstated only after recovery of the Dependent from the injury or sickness which necessitated a surgical operation for which benefits were payable.

Section S-2. SCHEDULE OF INSURANCE AND INITIAL PREMIUM RATES.—The insurance applicable to any Employee shall be in accordance with the schedule set forth below and any change in accordance with such schedule shall become effective, provided the Employee is then actively at work, on the date of change in the Employee's classification; if the Employee is not then actively at work, such change shall become effective on the date of his return to active work.

	Maximum Surgical Operation Benefit		Initial Monthly Premium Rate per Employee			
				Dependent Insurance		
	Employee	Dependent	Personal Insurance	Child or Children Only	Wife Only	Wife and Child or Children
NON-CONTRIBUTORY INSURANCE						
Employees at Plant A....	$250	$250	$0.72	$1.00	$1.70	$2.70
All other Employees.....	No Insurance		—	—	—	—
CONTRIBUTORY INSURANCE						
Employees at Plant A....	No Insurance		—	—	—	—
All other Employees.....	$350	$300	$1.01	$1.20	$2.04	$3.24

No Employee shall contribute to the cost of his Contributory Insurance more than the premium for such insurance. No Employee shall contribute to the cost of his Non-Contributory Insurance.

[Section S-3. MAXIMUM PAYMENTS FOR SURGICAL OPERATIONS.—The] payment for any surgical operation shall not exceed the amount specified for such surgical operation in the following Schedule. If the Maximum Surgical Operation Benefit in force hereunder on account of an Employee or Dependent is other than $250, the amount specified for a surgical operation or surgical operations shall be multiplied by the ratio which the Maximum Surgical Operation Benefit in force hereunder on account of the Employee or Dependent who undergoes such operation or operations bears to $250.

If more than one operation is performed through the same abdominal incision, the total payment for all such operations shall not exceed the greater of $175.00 or the maximum payment specified in the schedule for that one of such operations for which the largest amount is payable.

Surgical Operation	Maximum Payment
[Listings for "Abdomen." "Amputations," "Bones," "Breast," "Cardiovascular System," "Chest," "Dislocations, Reduction of," "Ear, Nose or Throat," "Endoscopic Procedures," and "Eye" are deleted for purposes of this Appendix.]	
Fractures, Treatment of:	
Unless otherwise specified the maximum payment is the payment for closed reduction or treatment. Maximum payment for open reduction or operation for treatment of compound fractures is twice the amount shown for closed reduction unless otherwise specified in the schedule but not exceeding $250.00.	
Epiphysial separations are considered fractures of the bone involved.	
Skull	
Depressed:	
Requiring dural repair	$ 250.00
Not requiring dural repair	125.00
Non-operative treatment	50.00
Facial Bones	
Nose	25.00
Mandible, or maxilla	50.00
Mandible, or maxilla open or closed reduction, with wiring of teeth or application of skeletal fixation	150.00
Facial bones (not otherwise classified)	25.00
Spine and Trunk	
Vertebra, body of: closed treatment (one or more)	100.00
laminectomy or spine fusion for	250.00
Vertebral process, one or more	25.00

Surgical Operation	Maximum Payment
Sacrum	50.00
Coccyx	25.00
Ribs: one	20.00
each additional	5.00
Sternum	25.00
Sternum, depressed-open reduction	100.00
Clavicle	40.00
Scapula	50.00
Pelvis:	
Closed reduction	75.00
With fracture and protrusion of the acetabulum	125.00
Open operation including repair of pelvic contents	250.00
Upper Extremity	
Humerus	100.00
Elbow, fracture into	100.00
Radius and/or ulna	100.000
Wrist: Carpal Bones—one or more	75.00
Metacarpal—one or more	50.00
Finger or thumb: one	30.00
each additional	10.00
Lower Extremity	
Femur	175.00
Tibia and/or fibula	125.00
Patella	65.00
Ankle, bimalleolar or trimalleolar	125.00
Astragalus and/or Os Calcis	100.00
Other Tarsal and/or Metatarsal bones	50.00
Toes: one	30.00
each additional	10.00

[Listings for "Genital System," "Hernia," "Joints," "Muscles—Cutting, Repairs, Suturing and Transplantation," "Nerves," "Obstetrical Procedures," "Paracentisis," "Rectum and Anus," "Skin and Subcutaneous Areolar Tissue," "Skull," "Spine", "Tendons," "Thyroidectomy," "Tumors," and "Urinary System" are deleted for purposes of this Appendix.]

The maximum payment for any surgical operation not specified in the above schedule shall be determined by the Insurance Company on the basis of the severity of the type of operation, in an amount consistent with the maximum payments for operations listed.

If Surgical Operation Insurance Benefits are paid hereunder for a surgical operation performed outside of a legally constituted

hospital while Hospital Expense Insurance under said Group Policy is in force on account of the person who underwent such operation, the Insurance Company shall pay, in addition to the payments otherwise provided, the amount of the actual expense, if any, charged for a general anesthesia and the administration thereof in connection with such operation up to a maximum of $10.

Section S-4. PAYMENT OF CLAIMS.—All benefits provided in this Rider shall be paid to the Employee as they accrue upon receipt of written proof covering the occurrence, character and extent of the event for which claim is made.

Section S-5. SURGICAL OPERATION PERFORMED AFTER CESSATION OF INSURANCE.—If any Employee or Dependent, at the date of cessation of the Surgical Operation Insurance on his account, is totally disabled as a result of injury or sickness and, while still so totally disabled and within thirty-one days after such cessation, undergoes a surgical operation, the Employee will be entitled to whatever benefits would have been payable hereunder in consequence of such surgical operation had such Surgical Operation Insurance continued in force without change to the date of such surgical operation.

If a female Employee or Dependent is pregnant at the date of the cessation of the Surgical Operation Insurance hereunder on her account and, as a result of such pregnancy and within nine months after such cessation, undergoes a surgical operation, the Employee will be entitled to whatever benefits would have been payable hereunder in consequence of such surgical operation had such Surgical Operation Insurance continued in force without change to the date of such surgical operation.

IN WITNESS WHEREOF, the Metropolitan Life Insurance Company has caused this Rider to be executed to take effect as of the effective date of the Rider as indicated on the first page hereof.

Secretary President

APPENDIX C

This Agreement by and between

GENERAL MOTORS CORPORATION
(Herein called the Employer)

and

METROPOLITAN LIFE INSURANCE COMPANY
(Herein called the Insurance Company),

WITNESSETH:

WHEREAS, the Employer is the holder of the Group Policies issued by the Insurance Company and listed in the following table (herein called the Group Policies) under which certain kinds of insurance, listed in said table for each such Group Policy as being subject to this Agreement, are provided for certain eligible Employees, as defined herein,

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to This Agreement
		The following kinds of insurance for Employees employed in the United States except for such insurance on (i) Employees who reside in the State of Connecticut, (ii) Employees who are employed in the State of California, and (iii) Surviving Spouses who contribute to the cost of the insurance on their own account and the insurance, if any, on account of their Dependents an amount equal to the premiums charged for such insurance.
22400-G	October 1, 1964	Surgical and Medical Expense Insurance, Hospital Expense Insurance and Prescription Drug Expense Insurance
24041-G	October 1, 1974	Vision Care Expense Insurance
24042-G	August 1, 1975	Comprehensive Medical Expense Insurance and Maternity Benefits

and WHEREAS, the Employer has established its Insurance Programs for Hourly-Rate and Salaried Employees (hereinafter referred to as the "Plan") providing benefits for certain Employees equivalent to those that would be payable under the kinds of insurance listed in said table, under which Plan the Employer will arrange to pay the benefits to which such Employees become entitled, and

WHEREAS, the Employer desires the Insurance Company to pay in any policy month, only those benefits becoming due under the Plan as are in excess of a stated aggregate amount paid by the Employer in such policy month, and

WHEREAS, the Insurance Company is willing to provide insurance under the Group Policies for that purpose,

NOW THEREFORE, it is agreed as follows:

(1) This Agreement and its provisions shall be attached to and become a part of each of the Group Policies and shall be effective January 1, 1976.

(2) The provisions of each of the Group Policies that apply to the kinds of insurance subject to this Agreement are modified to the extent set out in this Agreement, and to that extent the provisions of this Agreement shall govern notwithstanding anything in any of the Group Policies to the contrary.

(3) The provisions of this Agreement shall apply with respect to the Employees insured under each of the Group Policies for the kinds of insurance subject to this Agreement.

(4) While this Agreement remains in effect, the Insurance Company shall have the obligation to pay benefits otherwise expressed to be payable under the terms of the Group Policies, with respect to Employees whose insurance under the Group Policies is subject to this Agreement,

(a) during the first policy month in which this Agreement is in effect, and

(b) during any subsequent policy month only if and when the Employer has had paid from its funds benefits under the Plan during such policy month in an Aggregate Amount

determined in accordance with the provisions of the following paragraph (5),

and the Insurance Company shall have the obligation to pay from its funds such benefits only during the remainder of that policy month and during the remainder of any other such policy month. The Insurance Company shall also pay any benefits due which are the obligation of the Employer in accordance with paragraph (5) hereof but which are not paid from the Employer's funds, subject to reimbursement in accordance with paragraph (7) hereof.

(5) The point in time, if any, in each policy month, at which the Insurance Company's obligation to pay benefits from its funds shall commence, as stated in paragraph (4) above, shall be when the Employer shall have had paid from its funds during such policy month, in accordance with the Plan, benefits described in the following paragraph (6) on account of Employees covered under the Plan whose insurance under the Group Policies is subject to this Agreement, in an Aggregate Amount determined for that policy month in accordance with the following sentences. For the policy month in which this Agreement becomes effective and for the first policy month of each succeeding policy year, the Aggregate Amount is

$29.87 times the number of Employees reported by the Employer to be covered by the Group Policies for determining premiums for that policy month.

For each other policy month, the Aggregate Amount is the sum of

(a) $29.87 times the number of Employees reported by the Employer to be covered by the Group Policies for determining premiums for that policy month, and

(b) the amount, if any, by which the Aggregate Amount for the preceding policy month exceeds the benefits paid from the Employer's funds for such preceding policy month.

The Aggregate Amount for any policy month may be changed by agreement between the Employer and the Insurance Company.

(6) The benefits payable from the Employer's funds in each policy month, in accordance with the Plan, as referred to in paragraph (5) above, are as follows:

(a) Benefits with respect to all claims under the Plan for losses originating on or after the first day of that policy month, and

(b) Benefits with respect to claims under the Group Policies for losses originating prior to the first day of that policy month if such benefits were not paid prior to the first day of that policy month, it being expressly understood and agreed (i) that the amount of such benefit payments made from the Employer's funds shall be included with those specified in the preceding item (a) for the purpose of determining when the Insurance Company's obligation to pay benefits under the Group Policies, as hereby amended, shall commence in any policy month as stated in paragraph (5) above, and (ii) that the Insurance Company shall not reimburse the Employer for any such payments made from the Employer's funds other than for payments made during a period when the Insurance Company has the obligation to pay benefits under the terms of this Agreement.

(7) If any amount of benefits shall have been paid from the Employer's funds and such amount was an obligation of the Insurance Company pursuant to this Agreement, the Insurance Company shall reimburse the Employer for such payment. If the Insurance Company shall have paid from its funds any amount of benefit which was not an obligation of the Insurance Company pursuant to this Agreement the Employer shall reimburse the Insurance Company for such payment.

(8) The Insurance Company shall have the right to make final determination of the amount of benefits, if any, to which an Employee shall be entitled in any claim for benefits accruing under the Employer's Plan during any period in which the Insurance Company is not obligated to pay benefits from its funds pursuant to this Agreement, and the Employer agrees to accept and follow such determination in having such benefits paid from its funds pursuant to the Plan. Such determination shall be made

by the Insurance Company on the same basis used to determine entitlement to benefits during a period in which the Insurance Company is obligated to pay benefits from its funds pursuant to this Agreement. If the Insurance Company so determines that any claim shall be rejected and if any suit shall be brought with respect to such a claim, the Insurance Company agrees to undertake at its expense the defense of such suit and to pay any judgment rendered therein. The Insurance Company shall, however, have the right to settle any such suit when in its judgment it appears expedient to do so. If any such judgment or settlement is paid from the Insurance Company's funds during a period in which the Insurance Company is not obligated to pay benefits pursuant to this Agreement, the Employer shall reimburse the Insurance Company for the amount of benefit payments included in such judgment or settlement.

(9) In no case shall the Insurance Company be liable for the benefits payable from the Employer's funds, in accordance with the Plan, as stated in paragraph (6) hereof, nor shall the Employer be liable in any case for the benefits payable from the Insurance Company's funds under paragraph (4) and (13) hereof, it being agreed that the payments from the funds of the Employer as stated in paragraph (6) hereof, and of the Insurance Company pursuant to this Agreement, are and shall be mutually exclusive.

(10) The term "policy year" as used in these provisions means the period beginning with a renewal date of the Group Policies and ending with the day immediately preceding the next following renewal date or, unless the Insurance Company and the Employer shall agree otherwise, with the date of discontinuance of any of the Group Policies if prior thereto. The term "policy month" means the period beginning with a premium due date of the Group Policies and ending with the day immediately preceding the next premium due date. For the purposes of this Agreement, a loss originates upon the happening of an event for which benefits may be claimed; benefits become due upon receipt by the Employer or the Insurance Company of due proof in substantiation of a valid claim for such benefits.

(11) Instead of the method of computation of the premiums due under the Group Policies for the insurance subject to this Agreement, as set forth in the provisions of the Group Policies which relate to the computation of premiums thereunder, the Insurance Company shall determine for that purpose an aggregate average monthly premium rate for all such insurance to which this Agreement is applicable. The monthly premium rate for such insurance for the first policy year this Agreement is in effect, subject to the rights of the Insurance Company to change premium rates as specified in the Group Policies, shall be $5.30 per Employee reported by the Employer to be covered by the Group Policies for determining premiums or such other rate as may be agreed upon between the Insurance Company and the Employer. In addition to the premium, if any, otherwise due for the insurance under the Group Policies which is subject to this Agreement, an additional monthly premium shall be due and payable to the Insurance Company for the last month that this Agreement is in effect; such additional premium shall be equal to the excess of

(a) The total amount of premiums, as determined by the Insurance Company, which would have been payable since the end of the preceding policy year if this Agreement had not been in effect, over

(b) The sum of

(i) the premiums actually paid to the Insurance Company for the period from the end of the preceding policy year, and

(ii) the claims paid from the Employer's funds since the end of the first month of the then current policy year.

In addition to any other rights to change premium rates, the Insurance Company shall also have the right to change any or all premium rates if and when this Agreement is discontinued or the Employer modifies the Plan. In all other respects the provisions of the Group Policies which concern the due date, computation and payment of premiums thereunder shall continue unchanged by this Agreement.

(12) The Employer agrees to furnish the Insurance Company with all information which it may from time to time request for the purpose of carrying out the terms of this Agreement.

(13) This Agreement may be discontinued by the Insurance Company or by the Employer as of the day preceding any premium due date by giving written notice thereof to the other party at least 60 days prior to such date of discontinuance. This Agreement shall automatically be discontinued as of the earliest of the following dates:

(i) The last day of the policy month for which the Employer shall not have made funds available for the payment of all benefits stated to be payable from his funds in accordance with this Agreement.

(ii) The date as of which any of the Group Policies is discontinued, whether by written notice or cessation of premium payments.

Upon discontinuance of this Agreement the Insurance Company shall have the obligation to pay all benefits, if any, with respect to all insurance under the Group Policies which is subject to this Agreement, that become due in accordance with the provisions of the Group Policies after the date of discontinuance of this Agreement. Unless another arrangement satisfactory to the Insurance Company and the Employer is made, however, discontinuance of this Agreement for any reason shall not terminate the application of its provisions with respect to any benefits which became due prior to the date of such discontinuance.

IN WITNESS WHEREOF, the Employer and the Insurance Company have caused this Agreement to be executed by their respective officers duly authorized so to do.

At Detroit, Michigan this 5th day of June 1978.

Attest:

GENERAL MOTORS CORPORATION

Title: D.W. Schneider, Director
Employee/Benefit Plans
Administration

Title: R.M. Cone, Director
Insurance and
Pension Section

At New York, New York this 12th day of February 1979.

Attest:

METROPOLITAN LIFE INSURANCE COMPANY

GEORGE V. RICHARDSON
Title:

By ROBERT C. HOFFMAN
Title:

FORM G.9372

METROPOLITAN LIFE INSURANCE COMPANY

Agreement Form G.9372, entered into by and between GENERAL MOTORS CORPORATION and Metropolitan Life Insurance Company effective January 1, 1976, is hereby amended, as follows:

I. Effective July 1, 1977, by adding to the introduction to the kinds of insurance subject to said Agreement Form G.9372, the following:

", and except for Vision Care Expense Insurance on employees who are not hourly-rate employees in a bargaining unit for which International Union of Electrical, Radio and Machine Workers and one of its local unions is the duly certified collective bargaining representative."

II. Effective October 1, 1977, by substituting for the Table appearing in said Agreement Form G.9372, the following:

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to this Agreement
		The following kinds of insurance for Employees employed in the United States except for such insurance on (i) Employees who reside in the State of Connecticut, (ii) Employees who are employed in the State of California, and (iii) Surviving Spouses who contribute to the cost of the insurance on their own account and the insurance, if any, on account of their Dependents an amount equal to the premiums charged for such insurance, and except for Vision Care Expense Insurance on employees who are not hourly-rate employees in a bargaining unit for which International Union of Electrical, Radio and Machine Workers and one of its local unions is the duly certified collective bargaining representative
22400-G	October 1, 1964	Surgical and Medical Expense Insurance, Hospital Expense Insurance, Prescription Drug Expense Insurance and Hearing Aid Expense Insurance
24041-G	October 1, 1974	Vision Care Expense Insurance
24042-G	August 1, 1975	Comprehensive Medical Expense Insurance and Maternity Benefits

III. Effective January 1, 1978, by deleting from the Table in said Agreement Form G.9372, the following:

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to this Agreement
24041-G	October 1, 1974	Vision Care Expense Insurance

IV. Effective May 1, 1979, by substituting for the Table appearing in said Agreement Form G.9372, the following:

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to this Agreement
		The following kinds of insurance for Employees employed in the United States except for such insurance on Surviving Spouses who contribute to the cost of the insurance on their own account and the insurance, if any, on account of their Dependents an amount equal to the premiums charged for such insurance
22400-G	October 1, 1964	Surgical and Medical Expense Insurance, Hospital Expense Insurance, Prescription Drug Expense Insurance and Hearing Aid Expense Insurance
24042-G	August 1, 1975	Comprehensive Medical Expense Insurance and Maternity Benefits

The foregoing amendment is to be attached to and made part of each of the Group Policies, and is subject to the agreements and covenants therein contained.

Dated at Detroit, Michigan, this 12th day of January, 1983.

R. D. Anderson
(Witness)

GENERAL MOTORS CORPORATION
(Employer)

By R. L. SHERMAN

(SPACE BELOW FOR USE OF METROPOLITAN LIFE INSURANCE COMPANY ONLY)

Dated at New York, New York, this 14th day of January, 1983.

George L. Richardson
(Registrar)

METROPOLITAN LIFE
INSURANCE COMPANY

Harry P. Kamen
Secretary

Form 5955-G